COMMONWEALTH OF MASSACHUSETTS

Commission Against Discrimination
One Ashburton Place, Room 601
Boston, MA 02108
(617) 994-6000
(617) 994-6024 fax

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Case Name: _____
Docket No: _____
Date: _____
Answers Due by: _____

For Internal Use Only

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FOR COMPLAINANT:
QUESTIONNAIRE AND DOCUMENT REQUESTS ON
DISABILITY /REASONABLE ACCOMMODATION

1. Please identify the nature of your disability or disabilities.

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2. Please state whether your disability has been diagnosed by a medical professional, and if so, what was diagnosed, and the date it was first diagnosed.

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3. Please state whether you have suffered a work-related injury; if so describe how and when the injury was sustained and whether you have received workers compensation benefits.

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4. Please state whether you receive medical treatment for your disability, including the nature of the treatment you receive, when you first started to receive treatment, and how frequently you receive treatment.

5. Please describe in detail the frequency and extent to which your disability affects your daily life activities, for example, caring for yourself, performing manual tasks, walking, seeing, hearing, speaking, breathing, and learning.

6. Please state the expected duration of your impairment.

7. Please describe how and when your employer first learned you suffered from a disability, and

    a. If you informed your employer of your disability, please provide the name and job title of the person you informed, and the date in which you were provided the information.
    b. If you informed your employer in writing, please provide a copy.

8. Please provide your job title and describe your job duties.

9. Please state which of your job duties you believe to be the essential functions of your job and the amount of time you spend performing each of those duties.

10. Please describe in detail how your disability affects your ability to perform the essential functions of your job and what, if any, accommodation you require to perform those functions.

11. Please describe in detail any requests you have made for accommodation, including the following:

    a. the specific accommodation requested;
    b. how that particular accommodation is required to perform the essential functions of your job;
    c. the date of your request(s);
    d. copies of any requests;
    e. copies of any medical documentation submitted with your request(s).

12. Please describe in detail your employer's response to your requests for accommodation, including the following:

    a. the identity and position of the person responding to your request;
    b. the date(s) of response(s);
    c. the accommodation offered;
    d. the effect of the accommodation on your ability to perform the essential functions of your job.

13. Please state whether you have requested or taken a leave of absence of any length because of the disability named above and the dates of any such leaves. State whether a request for leave was ever denied. If so, state the reason for the denial. Please provide copies of any communications with your employer regarding disability-related leave.

14. Please provide copies of all medical documentation submitted to your employer and copies of any other communications with your employer regarding your disability and requests for accommodation.

15. Please provide copies of any other documents which support your claim that your employer discriminated against you on the basis of your disability.

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16. Please provide the names and telephone numbers of anyone who can provide information in support of your claims of discrimination.

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In addition to the documents already requested, please provide us with the following:

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Signature of Complainant Date

Please mail or fax your answers and supporting documents to:
Keith Healey / Tania Taveras at:

MCAD, One Ashburton Place, Room 601, Boston MA 02108 Fax: (617) 994-6040